Case Discussion: Management of CLL

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A 59-year-old male with a history of CLL diagnosed 15 years ago who was lost to up and no other PMHx presented with fatigue and dyspnea on exertion.

He was found to have WBC 370,000 (last 60,000), Hb 4.7 (last 12), platelets 18,000 (last 200,000). Bilirubin was 4.1 and haptoglobin was undetectable.

Diagnostic test	Result
Flow cytometry (PB)	distinct cell population expressing CD5, partial CD11c, CD19, CD20 (dim), CD22 (dim), CD23, partial CD25 (dim), HLA-DR, FMC7 (dim), and CD45. Surface immunoglobulin expression is dim intensity. CD38 expression is not detected.
Light chain	Lambda
IGHV	Unmutated (VH1-69)
FISH	FISH negative for del13q, del17p, del11q, del6q, and trisomy 12 TP53 not detected.
Bone marrow biopsy	CLL with no evidence of transformation.

DISCUSSION

What would you choose as the frontline treatment for this patient and why?

What regimen would you choose for hospitalized patients with CLL and how would you transition their care after discharge?

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He later developed a new diagnosis of hypertension that was eventually refractory to treatment. He was switched to acalabrutinib with a good response and normalization of blood counts.

Two years later, he presented with a WBC count of 60,000. C481S mutation was detected and acalabrutinib was discontinued.

DISCUSSION

Do you repeat CLL prognostic testing (e.g., TP53 status) at relapse? Why?

What is your approach to treatment of relapsed CLL after BTKi in this patient? What about in patients who initially received venetoclax?

What are some of the challenges faced with venetoclax-based regimens? Any practical tips for use in the community setting?

Q&A